Submit Completed Document To: IMDPlacement@azahcccs.gov

Attachment A, IMD Placement Exceeding 15 Days

Requesting Contractor Information

*Submitting Contractor Name: _____

*Submitting Contractor Contact Name: _____

*Submitting Contractor Contact Phone Number: _____

*Submitting Contractor Contact Email: _____

Was notification provided to other responsible entity? Yes__ No __ N/A (Integrated Member) __

Member Information

*Member Name – First/Last: _____

*Member DOB: _____

*Member AHCCCS ID: _____

* IMD Name: _____

*IMD Provider ID: _____

*First IMD Admit Date: _____

* First IMD Date of/Anticipated Date of Discharge: _____

*Total Days During the Calendar Month of First IMD Stay: _____

*Second IMD Admit Date: (if applicable) _____

* Second IMD Date of/Anticipated Date of Discharge: (if applicable) _____

*Total Days During the Calendar Month of Second IMD Stay: (if applicable) _____

* Third IMD Admit Date: (if applicable) _____

* Third IMD Date of/Anticipated Date of Discharge: (if applicable) _____

*Total Days During the Calendar Month of Third IMD Stay: (if applicable) _____

*Date of 16th Day of IMD Stay in Month: _____

or

*Date of 16th Cumulative Day of IMD Stay in Month: (if applicable) _____